☐ ALS ☐ BLS ☐ TRANSFER

☐ MULTIPLE PATIENTS

_____ OF _____

ROY FIRE & RESCUE
INCIDENT REPORT

INCIDENT #_____

INCIDENT DATE_____/_____/_____

DISTRICT CODE _____

INCIDENT ADDRESS	CITY	STATE	ZIP CODE	DISPATCHED

PATIENT'S NAME (LAST)	(FIRST)	PHONE	ENROUTE

AGE	D.O.B.	SEX ☐ M ☐ F	SS#	DISPATCH CODE	BLS ARRIVED

RESPONSIBLE PARTY LAST	FIRST	MIDDLE	RELATIONSHIP TO PATIENT	D.O.B.	ALS ARRIVED

STREET ADDRESS	CITY	STATE	ZIP CODE	PHONE	AMB ARRIVED

PRIMARY INSURANCE NAME	INSURANCE POLICY#	AUTOMOBILE INSURANCE NAME	INSURANCE POLICY #	ARRIVED AT PATIENT

TIME	PULSE RATE	BLOOD PRESSURE	RESPIRATIONS	SPO_2 w/o O_2	SPO_2 with O_2	TEMPERATURE	ENROUTE TO HOSPITAL
				%	% ☐ Mask ☐ Cannula		
				%	% ☐ Mask ☐ Cannula		PT ARRIVED HOSPITAL
				%	% ☐ Mask ☐ Cannula		AVAILABLE

WASTED MEDICATION:_____ DISPOSED:_____ mg WITNESS INITIAL_____

PAST HISTORY:
DENIES ☐

ALLERGIES:
DENIES ☐

MEDICATIONS:
DENIES ☐

NARRATIVE

REVISED TRAUMA SCORE			GLASGOW COMA SCORE	
RESPIRATORY RATE			EYE OPENING	
4	10 - 29	4	4 SPONTANEOUSLY	4
3	>29	3	3 TO SPEECH	3
2	9 - 6	2	2 TO PAIN	2
1	5 - 1	1	1 NONE	1
0	0	0		
SYSTOLIC B/P			VERBAL RESPONSE	
4	>89	4	5 ORIENTED	5
3	89 - 75	3	4 CONFUSED	4
2	74 - 50	2	3 INAPPROPRIATE	3
1	49 - 1	1	2 INCOMPRENSIBLE	2
0	0	0	1 NONE	1
GLASGOW SCORE			MOTOR RESPONSE	
4	13 - 15	4	6 OBEYS COMMANDS	6
3	9 - 12	3	5 LOCALIZES PAIN	5
2	6 - 8	2	4 WITHDRAWS TO PAIN	4
1	4 - 5	1	3 FLEXES TO PAIN	3
0	3	0	2 EXTENDS TO PAIN	2
			1 NONE	1
1ST TOTAL	2nd TOTAL		1ST TOTAL	2nd TOTAL

	DRIVER PM	PATIENT PM	TRAINING PM
ALS UNIT #	EMS #	EMS #	EMS #
AMBULANCE #	DRIVER PM/EMT	PATIENT PM/EMT	FF PM/EMT
	EMS #	EMS #	EMS #
FIRST RESPONSER	DRIVER PM/EMT	OFFICER PM/EMT	FF PM/EMT
	EMS #	EMS #	EMS #

BLOOD GLUCOSE			
E.K.G			
HOSPITAL DELIVERED		CODE	
REASON FOR TRANSPORT	MILEAGE BEGIN	END	TOTAL
TRANSPORT BILLING CODE			

PMA001 _____ South Ogden PMA002 _____ North View PMA005 _____ Syracuse PMA007 _____ Clinton PMA009 _____ Layton PMA011 _____ DCSO
PMA002 _____ Ogden PMA004 _____ Weber PMA006 _____ Morgan PMA008 _____ N. Davis PMA010 _____ Other

51000 _____ BLS Transfer
51010 _____ BLS
51011 _____ ALS
51022 _____ ALS II
51060 _____ Inter-Trans
51033 _____ Specialty Care
52000 _____ Mileage
51050 _____ Non-Transport

30050 _____ Auto Vent
21758 _____ Bandaging
21619 _____ Blood Draw
21572 _____ BSI
30090 _____ EKG Monitor
30010 _____ Equip. Decontamination
30110 _____ Intubation Kit
00290 _____ EZ IO
06006 _____ IV Set-up
00070 _____ O^2 Admin
00009 _____ Resuscitation Kit
30060 _____ Spine Immobilization
30120 _____ Splinting
30080 _____ Suction

SUPPLIES

00872 _____ Atomizer
21583 _____ Bed Pan
21509 _____ Bite Stick
21510 _____ Body Bag
01315 _____ Bulb Syringe
00216 _____ Burn Sheet
21613 _____ Butterfly Needle
00230 _____ Cold/Heat Pack
00245 _____ Cric Kit
00300 _____ Emesis Collect
30150 _____ ET CO^2 Sensor
A0092 _____ Fast Patch (Adult)
A0094 _____ Fast Patch (Ped LP12)
A0095 _____ Fast Patch (Ped LP1000)
00585 _____ Glucose Strips
00258 _____ Glutose
21584 _____ Male Urinal
00830 _____ Meconium Aspirator
01005 _____ Nebulizer
00920 _____ OB Kit
21589 _____ Porta Warmer
30160 _____ Sebs Bag
30170 _____ SPO^2 Sensor
01405 _____ Syringes
21590 _____ Toll Fee
00285 _____ Vaseline Dressing

MEDICATIONS

001 _____ Activated Charcoal
002 _____ Adenosine
005 _____ Albuterol (Proventil)
020 _____ Atropine
025 _____ Baby Aspirin
030 _____ Benadryl
247 _____ D25
090 _____ D50
070 _____ Demerol-Meperdine
120 _____ Dopamine
281 _____ Epi Pen
100 _____ Epinephrine 1:1000
110 _____ Epinephrine 1:10,000
115 _____ Haldol - Haloperidol
283 _____ Ibuprofen
130 _____ Ipecac Syrup
160 _____ Lasix - Furosemide
260 _____ Lidocaine
250 _____ Lidocaine Drip
180 _____ Morphine Sulfate
190 _____ Narcan
200 _____ Nitroglycerin
210 _____ Phenergan
220 _____ Pitocin - Oxytocin
230 _____ Sodium Bicarbonate
081 _____ Tylenol
240 _____ Valium-Adult
241 _____ Valium-Pediatric
176 _____ Versed
311 _____ Zofran
280 _____ Other Medications _____

(1) RFD (BILLING) COPY (2) HOSPITAL COPY

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TRANSPORT REFUSAL

This is to certify that I am refusing treatment / transport. I have been informed of the risk(s) involved, and hereby release Roy City, its attendants, and its affiliates, from all responsibility which may result from this action.

☐ **Individual refused to sign**

_____
Patient Signature Date/Time

MEDICARE SIGNATURE / NOTICE OF PRIVACY PRACTICES

I, _____ X _____
PLEASE PRINT NAME SIGNATURE

☐ **AUTHORIZE** the ambulance provider listed on this form to bill Medicare/Medicaid/Insurance Companies on my behalf and acknowledge receipt of a copy of a Notice of Privacy Practices (NPP).

☐ Individual refused to sign NPP ☐ Communication barriers prevented obtaining the NPP acknowledgement
☐ Emergency situation prevented obtaining the NPP acknowledgement ☐ Other _____

☐ The patient is **MENTALLY AND/OR PHYSICALLY UNABLE TO SIGN** Authorization to Bill Medicare/Medicaid/Insurance Companies and there were no other authorized signers available or willing to sign.

AUTHORIZED REPRESENTATIVES include only the following individuals (check one):
☐ Patient's Legal Guardian ☐ Patient's Health Care Power of Attorney
☐ Relative or other person who receives government benefits on behalf of patient
☐ Relative or other person who arranges treatment or handles the patient's affairs
☐ Representative of an agency or institution that furnished care, services or assistance to the patient

☐ Acknowledge receiving the patient at the **FACILITY** noted on this form

I am signing on behalf of the patient. I recognize that signing on behalf of the patient is not an acceptance of financial responsibility for the services rendered.